

Blue Shield of California
Blue Shield of California Life & Health Insurance Company
Dental Plan and Dental + Vision Package Application



This form is to be used by applicants applying for a Blue Shield dental plan or dental + vision package.
 For applicants with no Blue Shield coverage, please complete the entire form.
 For applicants with existing Blue Shield coverage, please complete the shaded area of the form.

You are eligible for any Individual & Family (IFP) dental plan or dental + vision package if you are a California resident at the time of enrollment. If you had a Blue Shield Individual & Family dental plan cancelled for any reason (by yourself or by Blue Shield), you must wait 6 months from the date of cancellation before you can reapply, unless there is no lapse in coverage between Blue Shield dental plans. Blue Shield will not approve concurrent enrollment in two Blue Shield IFP dental plans or dental + vision packages. If you enroll in any HIPAA Guaranteed Issue plan, you are not eligible for dental plan or dental + vision package.

Part 1 – Coverage, plan, and applicant information

Coverage Options: New enrollment Add dependent family member to existing coverage

Dental plan or dental + vision package: (please check one below)
 Smile PPO* Value Smile PPO* Specialty Duo (dental + vision) package*
 Requested effective date: _____

To find a Blue Shield dental or vision provider by name, location, and specialty, go to our website blueshieldca.com.

Applicant Information

Applicant Social Security number		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of birth (mo/day/yr) / /		Married: <input type="checkbox"/> Yes <input type="checkbox"/> No Domestic partnership: <input type="checkbox"/> Yes <input type="checkbox"/> No	
First name			MI	Last name			
Do you currently have dental coverage through Blue Shield? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please indicate plan		Dental subscriber number (if applicable)			
Do you currently have medical coverage through Blue Shield? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please indicate plan		Medical subscriber number (if applicable)			
Do you currently have vision coverage through Blue Shield? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please indicate plan		Vision subscriber number (if applicable)			
Applicant business phone number		Applicant home phone number		Applicant fax number			
Applicant home address						Apt No.	
City				State		ZIP code	
Applicant billing address (if different from home address)						Apt No.	
City				State		ZIP code	
Applicant mailing address (if different from home address)						Apt No.	
City				State		ZIP code	
E-mail address				Best time to contact by phone			
Language preference: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other _____							
Payment options: <input type="checkbox"/> Monthly direct billing <input type="checkbox"/> Quarterly direct billing							

Part 2 – Dependent information

List all dependent family members you wish to cover (dependent children must be under age 26).

1. Husband Wife Domestic partner (circle one): Male Female

First name		MI	Last name (if different from above)	
Social Security number			Date of birth (mo/day/yr) / /	

2. Son Daughter

First name		MI	Last name (if different from above)	
Social Security number			Date of birth (mo/day/yr) / /	

3. Son Daughter

First name		MI	Last name (if different from above)	
Social Security number			Date of birth (mo/day/yr) / /	

* Pending regulatory approval.
 † Underwritten by Blue Shield of California Life & Health Insurance Company

Part 3 – Authorizations, terms, and conditions

Please read the following terms and conditions carefully. Your authorization and signature is required below.

- 1. Eligibility:** I understand that Blue Shield has the right to decline my application for coverage. I also understand that I must be residing in California and not enrolled in any HIPAA Guaranteed Issue medical plan in order to be eligible for enrollment in this plan/package. I will notify Blue Shield upon any change regarding my eligibility for this plan. I also agree to provide, or provide access to, information requested by Blue Shield to verify my eligibility, or continued eligibility, for coverage, and understand that failure to cooperate could result in cancellation of coverage.
- 2. First payment of dues/premium:** Attached is my personal check or money order in an amount equal to one month's dues/premium made payable to Blue Shield of California. I understand cashing of my check by Blue Shield does not constitute enrollment in the dental plan or dental + vision package. If I am not eligible, the amount of prepaid dues/premium will be refunded to me.
- 3. Dues/premium payments:** Dues/premiums are to be paid by the due date. Coverage will be terminated for failure to pay dues/premiums in a timely manner as set forth in the Evidence of Coverage and Health Service Agreement/Policy.
- 4. Effective date of coverage:** If my application is approved, Blue Shield will inform me in writing of the effective date of coverage for me and any enrolling dependents. If Blue Shield cannot honor my requested effective date, or is unable to issue coverage before my requested date, coverage will begin as soon as possible. **Charges incurred before my effective date or after termination of coverage are not covered.**
- 5. Entire agreement:** If approved, this application, together with the Evidence of Coverage and Health Services Agreement/Policy, any endorsements, appendices, and attachments thereto, will collectively constitute the entire agreement for dental or dental + vision coverage with Blue Shield. My agent cannot approve this application for coverage or change any terms or conditions of coverage.
- 6. If the applicant is a minor:** The parent or legal guardian must sign on behalf of the any minor under the age of 18. The parent or legal guardian is identified as the person who may make inquiries and act on behalf of the applicant regarding this coverage (as allowed by law). In addition, the parent or legal guardian will assume all responsibility for dues/premium payments and for following the terms and conditions of coverage. Please indicate the relationship to the minor:
 A. Parent
 B. Legal guardian (attach copy of court documents)
- 7. Authorization for dependent spouse/domestic partner to make changes:** If my dependent spouse/domestic partner is enrolling for dental or dental + vision coverage, I authorize my spouse/domestic partner changes to the contract on my behalf. Yes No
I may discontinue this authorization at any time by sending a written request to Blue Shield.
- 8. HIV testing prohibited:** California law prohibits an HIV test from being required or used by a health insurance company or a healthcare service plan as a condition of obtaining health coverage.

THIS SECTION MUST BE COMPLETED BEFORE YOUR APPLICATION CAN BE PROCESSED. KEEP A COPY OF THIS APPLICATION FOR YOUR RECORDS.

I have reviewed all responses pertaining to me in this application, I have read the summary of benefits and the terms and conditions of coverage and authorizations set forth above. With my own signature below, I represent that the information provided in this application is complete and accurate to the best of my knowledge, and I understand and agree to the terms and conditions of coverage and the authorizations I have provided. (Important: Each adult applicant must provide their own signature).

Signature of applicant	_____/_____/_____ Today's date (required)	_____ Print name
Signature of spouse/domestic partner	_____/_____/_____ Today's date (required)	_____ Print name
Signature of dependents age 18 or over (if applying)	_____/_____/_____ Today's date (required)	_____ Print name
Signature of dependents age 18 or over (if applying)	_____/_____/_____ Today's date (required)	_____ Print name

Producer information

Producer number	063287258	Telephone number	877-566-5454	Fax number	310-827-0256
E-mail address	insure@barricksinsurance.com				
Producer address	13900 NW Passage #302				
City	Marina Del Rey	State	CA	ZIP code	90292
Super producer name	James Barricks	Super producer number			
Do you want the Evidence of Coverage and Health Services Agreement/Policy sent directly to the subscriber? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					

_____ Producer signature	_____/_____/_____ Today's date	James Barricks _____ Print name
-----------------------------	-----------------------------------	--

NOTICE: Please ensure each part of the application is complete. In the event of missing or incomplete information Blue Shield may contact your applicant directly to obtain complete information.

Please fax or mail the completed and signed application to:

Installation and Membership
Blue Shield of California
P.O. Box 3008
Lodi, CA 95241-1912
Fax: (209) 367-6490

For internal use only DSA name: _____ DSA number: _____ Producer number: _____
--